



Why are so few physicians treating addiction? What can we do about it?

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Methods



- Literature review
- Qualitative interviews with 22 physicians

Why we need physicians treating addiction



- MAT
- SBIRT
- Seeing patients with addiction: (CDC 2016)
 - In primary care settings, 3% to 26%
 - In pain clinic settings, 2% to 14%
- Survey of 495 psychiatrists: > 20% patients have SUD (Thomas 2008)

Low Physician Involvement



- Nat'l survey of 648 physicians (CASA 2000)
 - only 55 % reported routine referrals
 - 15 % did no interventions
- Nat'l survey of 510 adults receiving treatment (CASA 2000)
 - 11% of patients' PCP knew about addiction but did nothing

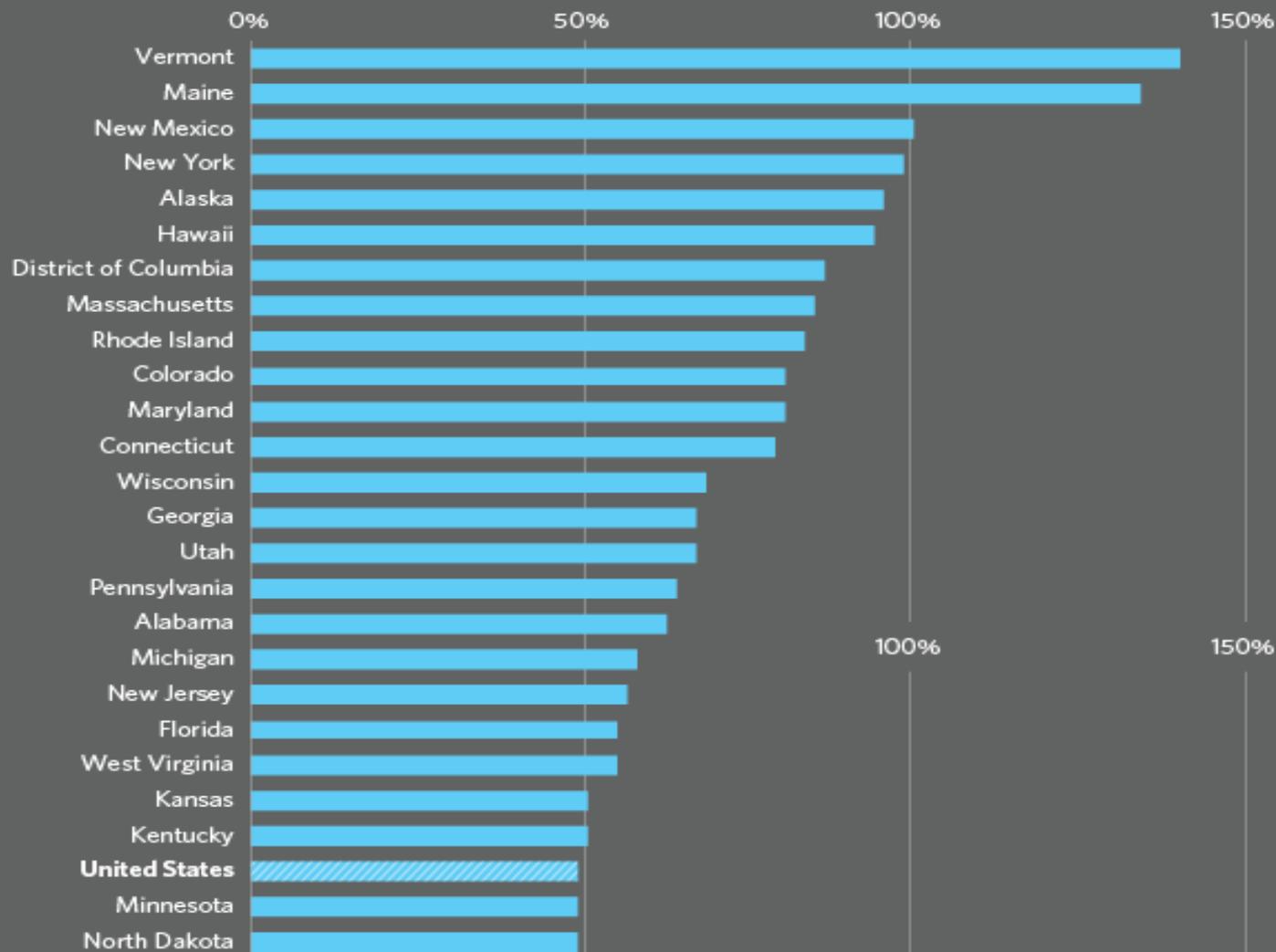
Low rates of MAT prescribing

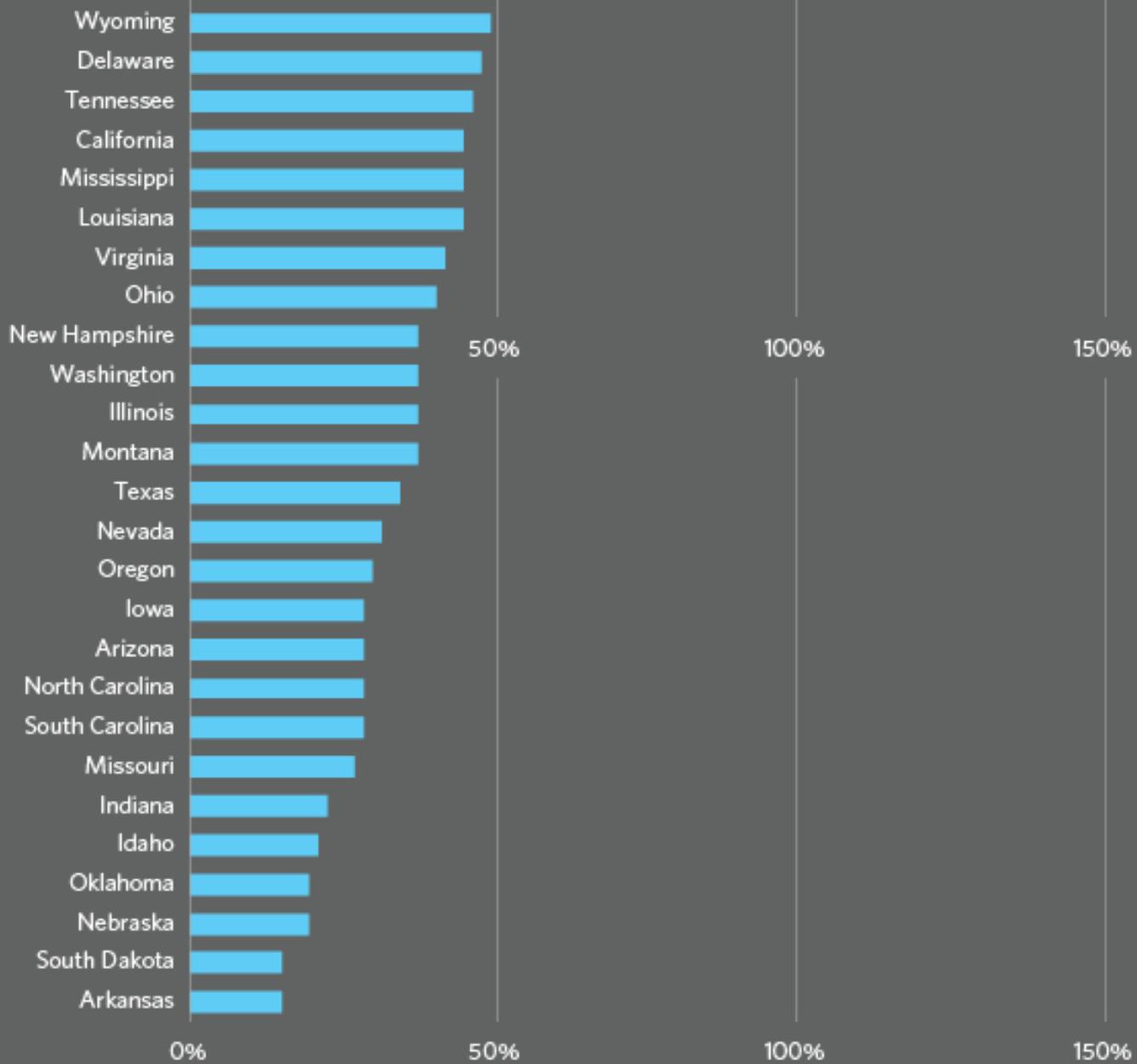
- Treatment centers:
 - < 45% provide any MAT (Roman et al. 2011)
 - <1% of eligible patients receive Vivitrol (SAMHSA 2014)
- Methadone:
 - 13 states have < 5 OTPs (Egan 2010)
 - 5 states have no OTP (Egan 2010)
- Buprenorphine
 - 1203 psychiatrists surveyed: 81% not comfortable prescribing (ASAM 2016):
 - 46% of counties lack a prescriber (Rosenblatt et al. 2015)
 - Only 13% of non-addiction psychiatrists have waiver/exempt (Thomas 2008)
 - > 900,000 physicians can prescribe oxycodone; < 32,000 can prescribe buprenorphine (Pew Trusts 2016)

Too Few Prescribers

The data below represent the number of patients who could receive the addiction treatment medication buprenorphine if every doctor who is authorized to prescribe it served the maximum number of patients allowed. In practice, very few physicians prescribe anywhere near their limit of 100 patients. As a result, fewer than half of all people in the U.S. who could benefit from the addiction medication are able to receive it.

■ Percentage of people with an opioid addiction for which buprenorphine is potentially available





Source: American Journal of Public Health

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Historical Separation of Physicians



- 1914: Harrison Narcotics Tax Act-only “prescribed in good faith”
 - *Webb v. U.S.(1919) & United States v. Doremus (1925)*
 - maintaining an addict “for the sake of continuing his accustomed use” is such a “plain perversion of meaning that no discussion is required” (p. 132)
 - Feds raid: 10% of DRs arrested are convicted & imprisoned
 - *Lindner v. United States (1925) & Boyd v. United States (1926)*
 - Distinguish between physicians prescribing in “good faith” to relieve suffering v. to enable drug abuse
 - Physicians leave addiction practice
- Some psychiatrists provide psychoanalysis but discredited (White 1998)
- Counselors and 12 steps fill void (White 1998)

Problem: Assuming few patients with addiction



- Nat'l survey of 648 PCPs and 510 adults in 10 facilities (CASA 2000)
 - 94% physicians failed to diagnose SUD
 - 43% of patients said physician failed to diagnose SUD
- Why low screening rates? (Ram & Chisolm, 2016)
 - Difficult or unpleasant
 - peripheral to medical matters
 - low reimbursement rates
 - lack of available treatment resources

Solution: Increase Screening



- Screen everyone
- Delegate (Harrison & Yu 2016)
- Use validated screening tools → Medicaid reimbursement (Harrison & Yu 2016)

Problem: Assuming Treatment is Ineffective



- Moral or willpower issue
- Treatment ideology as a barrier (substituting drugs)
- See addiction as acute rather than chronic (McLellan et al. 2000)
- Lack of awareness (Roman et al. 2011)
- Assume patients unsatisfied with Bup (9% prescribers v. 65% non-prescribers) (DeFlavio et al. 2015)

Solution: See effective treatment



- Education in med school, residency, CME
- See longitudinal treatment
- Address abstinence only ideology
- Chronic disease emphasis
- Harm reduction → effect on other conditions
- Mainstream MAT

Problem: Education Gap



- Med school:
 - 1% of educational curriculum (IoM 1997); rarely its own course (Ram & Chisolm 2016)
 - Low quality edu (Wakeman et al. 2013)
 - Few faculty mentors (Miller, Sheppard, Colenda, Magen 2001)
- Residency:
 - 62% residents unprepared to treat addiction (O'Connor, Nyquist & McLellan 2011)
- Practicing physicians
 - 90% PCPs unprepared to treat addiction (Tanner et al. 2012)
 - most psychiatrists uncomfortable prescribing bup (ASAM 2016)

Solution: Education in Pre-Clinical Years



- Forming professional identity (Ram & Chisolm 2016)
- Increase empathy levels before clinical rounds (Ram & Chisolm 2016)
- Separate course
- Volunteer electives
- Federal govt funding contingent upon SUD educ

Solution: Education in Clinical Years



- Med schools identify EBP centers as training sites
- Questions about addiction on licensing exam
- Longitudinal training

Solution: Education in Residency



- Encourage students to obtain SAMHSA waiver
- Demonstrate positive attitudes towards SUD patients with med students
- SUD edu in every residency

Solution: Training for Practitioners



- Even brief training works (Gunderson et al. 2009)
- Computerized training & in-person (especially w/ patients) (Gunderson et al. 2006)
- Ongoing is best
- Free buprenorphine certification course (e.g. Maryland)
- SAMHSA mentoring program (Egan et al. 2010)

Solution: CMEs



- SUD CME requirements for patients with DEA waiver (some exceptions)
- Fed CME guidelines, but states decide
- VA system as model for opioid prescribers (CARA 2016)

Problem: Presuming Patients are “Difficult”



- Lack of comfort dealing w/ social issues
- Difficulty providing referrals
- Complex
- Believe patients are lying so don't ask questions (CASA 2000)
- Lack of empathy

Solution: Interpersonal Skills Training



- Patient interviewing skills
- Mentoring
- Education of complex psychiatric conditions
- Emphasize referrals if complex (for PCPs)
- Small group debriefings with mentor

Problem: Stigmatization



- Poor attitude → low willingness → worse clinical outcomes (Meltzer et al. 2013)
- Esp. towards ppl who inject drugs
- Worrying about mix of patients
- Worrying about provider reputation

Solution: Education **Encompasses Attitudes**



- Mentors demonstrate lack of stigma
- Increasing contact with individuals with SUD
- Attitudes education component
- Choice v. disease

Problem: Psychiatrists only



- Too few → waiting times → deadly & discouraging
- PCPs: geographic dispersion, lower cost, gate keepers, family history, absence of stigma
- Buprenorphine waiver distribution: (Rosenblatt et al. 2015)
 - 16% of psychiatrists (41.6% of all physicians with waivers) - primarily urban
 - 3% of PCPs

Solution: Encourage PCPs



- Hub & Spoke Model, Vermont (Mann 2014)
- General satisfaction prescribing MAT (Becker 2006)
- Staff support (NPs)
- Increase awareness of SAMHSA Physician Clinical Support System
- Greater reimbursement to counteract minimal time

Problem: Low Collaboration with Therapists



- Navigation of community resources
- Abstinence-only counselors (Fitzgerald & Dennis McCarty 2006)
- Therapists not sending patients to physicians (Thomas 2008)
- Not enough counselors-esp. rural areas (Quest et al. 2012)

Solution: Promote Counselor Interaction



- Counselor education
- Medical schools: options to experience MDT case conferences
- State database of resources

Problem: Regulatory Barriers



➤ **Buprenorphine**

- No other Sched III meds have patient limits
- CARA allows NPs/PAs
- Probuphine: certification for implant required, patient limits?

➤ **Methadone: OTPs only**

- Separation from “mainstream” health
- Stigma
- Daily travel (take home rules vary)

Solution: Decrease Regulatory Barriers



- Stop treating MAT differently!
- Allow methadone prescribing outside of OTPs for stable patients → addiction specialists → PCPs (e.g. Scotland, Canada, Australia, Netherlands)
- Improve perception of individuals w/ SUD by integrating into community care models
- Clarify “capacity refer to counselor” rule

Problem: Insurance Barriers



- Only 13 states Medicaid programs cover buprenorphine, methadone & Vivitrol (Mann 2014)
- Probuphine? (Shakerdge 2016)
- “lifetime” Medicaid limits on buprenorphine
- Prior authorization hell
- Fail first (oral v. injectable naltrexone)
- Low Medicaid reimbursement rates + low time
- Detox not covered → hard to use Vivitrol

Solution: Eliminate Insurance Barriers



- Better enforcement of MH & SUD Parity violations
- All MAT on Medicaid formulary
- CMMS should prohibit “lifetime limits”
- Prohibit prior-authorization “weaning” requirements
- Increase Medicaid reimbursement rates
- Cover opioid detox

CONCLUSION



- Too severe a crisis to ignore
- Piecemeal solutions unlikely to be effective
- Coordination between insurance providers, govt, med schools, physician orgs
- Govt has a stake (\$\$\$\$)

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Questions?



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